Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HOSPITAL SYSTEM
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-99-2832-01

MFDR Date Received
August 17, 1998

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have enclosed a hospital bill for services rendered by Memorial Hospital System. We request that this bill be reprocessed for additional payment based on Fair and Reasonable Guidelines in existence immediately prior to the per diem rate structure."

Amount in Dispute: $5,945.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Petitioner did miss the one year filing deadline for dispute resolution as outlined in Commission Rule 133.305(a). Therefore, the Commission has no jurisdiction in this dispute."

Response Submitted by: Texas Workers' Compensation Insurance Fund, 221 West 6th Street, Suite 300, Austin, Texas 78701-3403

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 1997 to January 7, 1997	Inpatient Hospital Services	$5,945.57	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following payment exception codes:

- F – REIMBURSED IN ACCORDANCE WITH THE TEXAS HOSPITAL INPATIENT FEE GUIDELINE TEXAS HOSPITAL INPATIENT FEE GUIDELINE.
- N – DOCUMENTATION HAS NOT BEEN SUBMITTED TO SUBSTANTIATE THE SERVICE BILLED.

Findings

1. The requestor has listed the dates of service in dispute on the form TWCC-60 request for medical fee dispute resolution as October 6, 1997 to October 7, 1997. Review of the submitted information finds no documentation to support that any services were rendered on October 6, 1997 to October 7, 1997. However, the Division notes that the dates of service on the submitted medical bill are from January 6, 1997 to January 7, 1997. The Division concludes that the dates of service listed on the requestor's form TWCC-60 are the result of a typographical error. Therefore, the Division will deem the dates of service in dispute to be January 6, 1997 to January 7, 1997 for the purpose of this review.
2. 28 Texas Administrative Code §133.305(a), effective June 3, 1991, 16 *Texas Register* 2830, requires that "A request for review of medical services and dispute resolution, as described in the Texas Workers' Compensation Act (the Act), §8.26, shall be submitted to the commission at the division of medical review in Austin, no later than one calendar year after the date(s) of service in dispute." The applicability of the one-year filing deadline from the date(s) of service in dispute was confirmed in the court's opinion in Hospitals and Hospital Systems v. Continental Casualty Company, 109 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). Per 28 Texas Administrative Code §102.3(a)(3), effective January 1, 1991, 15 *Texas Register* 6747, "unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day." The request for dispute resolution of services rendered on dates of service January 6, 1997 to January 7, 1997 was received by the Division on August 17, 1998. Review of the submitted documentation finds that the request was submitted more than one year after the date of service. The Division finds that the request for dispute resolution was not submitted timely. The Division concludes that the requestor has not met the requirements of §133.305(a).
3. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
4. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
5. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of any explanations of benefits or copies of any medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
6. Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "We request that this bill be reprocessed for additional payment based on Fair and Reasonable Guidelines in existence immediately prior to the per diem rate structure."
   - The Division notes that former Division rule at 28 Texas Administrative Code §42.110(b)(2) is not applicable to the services in dispute. As noted above, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). Therefore, reimbursement under a

methodology as set forth in a prior rule cannot be favorably considered when no other information was found to support that the amount sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor's *Memorial Hermann Hospital System Response to TWCC Advisory 98-01* numbered paragraph 4 states that "the request for reimbursement does not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by the individual or by someone acting on that individual's behalf." However; numbered paragraph 1 indicates that the requestor negotiated managed care contracts for reimbursements ranging between 70% and 90% of billed charges. The requestor is seeking reimbursement at 92% of the billed charges for the services in dispute. Given that the requestor states that it discounts it's services provided under managed care contracts at various rates between 70% and 90%, the Division finds that the requestor has not supported its assertion that the request for reimbursement does not provide for payment of a fee in excess of the fee charged for similar treatment of an individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.
- The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not demonstrate the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor did not demonstrate or support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

7. The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was neither timely filed, nor filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	December 28, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for

a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.